

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045859

FILED VS JAN 9 1961

Registration District No. <u>141</u>		Primary Registration District No. <u>3822</u>		Registrar's No. <u>189</u>		STATE FILE NUMBER	
1. PLACE OF DEATH a. COUNTY <u>Moore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Moore</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in lb <u>61 yrs</u>		c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Rt 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Martin</u> Last <u>Bass</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-99</u>	
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White Church</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jno Bass</u>		13b. MOTHER'S MAIDEN NAME <u>L. Eldershoff</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Bass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Bertha Bass, West Plains, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>and Hypertension</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u>11:00</u> a.m. Month, Day, Year <u>12/22/60</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>22/12/60</u> to <u>22/12/60</u> and last saw him alive on <u>22/12/60</u> . Death occurred at <u>11:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>West Plains, Mo</u>		22c. DATE SIGNED <u>29/12/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/24/60</u>		23b. DATE <u>12/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>	
24. FUNERAL DIRECTOR <u>Robertson</u>		ADDRESS <u>West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-3-61</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

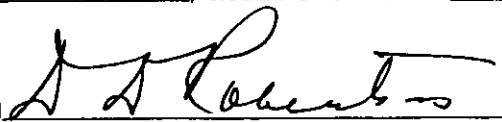
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 3432

P. O. Address Meat 72

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.